Four Pines Physical Therapy, PC

Patient Information Sheet

Last Name_____ First Name_____ MI____SSN_____

Mailing Address_____City_____ST____ZIP_____

Home Phone_____ Cell Phone _____ Work_____

Date of Birth_____ Gender___ Email_____

Appointment reminders (choose one) by: Voice____ Email____ Text _____

Current Employer_____ Phone_____

Address_____City_____ST_____Zip_____

Emergency Contact

Name_____ Phone_____ Relation_____

Problem Description_____ Date of Injury_____

Referred by_____ Primary Dr. _____ Phone_____

Primary Insurance_____ Subscriber_____

Relationship to insured _____ Date of Birth_____

Secondary/Supplemental Insurance_____ Subscriber _____

Relationship to insured _____ Date of Birth_____

Have you received physical therapy treatment within the last year (please circle): Yes / No

IF Worker's Comp (check here) _____ **IF motor vehicle accident** (check here) _____

Current Medications – please list all medications (prescriptions, over the counter medications, herbals, vitamins, minerals and dietary supplements). Include dosage, frequency, purpose, and administration method.

Medication	Dosage	Purpose	Frequency	Method of Administration

___ I am not taking any medications, vitamins or supplements not on this list at this time. See attached list _____

 If no changes to the above please sign here: _____ Date: _____

Payment/Insurance Policy

For your convenience, we will bill all insurance companies. Complete and accurate insurance information plus a copy of your card must be provided at time of service. We suggest you contact your insurance to know your coverage. Any non-covered services are your responsibility and payment is required at time of service. We will accept payment directly from your insurance company with the following provisions:

1. Patient agrees to provide insurance information to Four Pines Physical Therapy's physical therapists and staff.
2. Patient authorizes notice to the insurance company of assignment below.
3. If your insurance company pays you directly, you have 10 days to provide us with the explanation of benefits and the amount paid by the Insurance.

In the absence/cancellation/denial by the insurance company, the patient is responsible for the account. Unpaid accounts **90** days past due will be sent to an outside COLLECTIONS company. In addition to unpaid portion of account, the patient is responsible for collection fees and interest charges on the past due account. **Client's who have not met their deductible, have a co-payment or co-insurance that has not been met, will be billed at time of service.**

Initial_____

Accounts must be paid within 8 **months** of insurance processing. **Initial**_____

A late fee of $25 per month will be added to your unpaid balance that is 60 days or more overdue. The total balance may be paid in full at any time without penalty or additional finance charge. **Initial**_____

I give permission to this office, it's service providers, collection agencies, successors and assigns to email/dial/text/leave a message on any phone/voicemail/email address of any phone (home and cell phones)and emails provided by or otherwise owned by me or my spouse which may be include the name of company dialing the call, regarding services provided and my financial obligations regarding those services. **Initial**_____

Attendance Policy: Please see the attached policy which requires a minimum notice to be given of any change or cancellation by at least 12:00 p.m. the day prior to your appointment or if on a weekend, by Monday at 7:00 a.m. A **$75.00** fee will be charged for **No Show** or **Same Day Cancellation** with less notice. Emergencies that require canceling a scheduled appointment will be handled on a case by case basis. **Initial**_____

Notice Regarding Insurance Company Assignment

In the event my insurance company makes payment for services provided by Four Pines directly to me, I agree to immediately remit all such payments to Four Pines to be applied to my account balance. I acknowledge that all unpaid balances are my responsibility as noted above. I hereby authorize the insurance company to provide the clinic with any information regarding the processing and payment of my insurance claim.

I have read and understand the Financial Policy for Four Pines Physical Therapy, PC. I understand that I am responsible for any balance due. Accounts with balance will be subject to interest rate of 1.75% after 90 days.
I authorize treatment by the Staff of Four Pines Physical Therapy, PC
I authorize payment of medical benefits to undersigned provider or supplier for these services and all future claims.
I authorize the release of any medical information necessary to process this claim and all future claims.
I authorize release of information to my referring physicians and lawyer if needed for MVA
I agree to comply with the terms and conditions as outlined on the Patient Registration form.
I hereby acknowledge that I have received a copy of the Notice of Health Insurance Privacy Policies Act.

Patient/Guarantor_____ **Date**_____

Rev: 9/2019

 If no changes to the above please sign here: _____ Date: _____

Name: _____ Age: _____ Occupation: _____

Date of Injury: _____ Date of Surgery (if applicable): _____ Date of last physical: _____

Medical History: (check all that apply and circle if multiple options per line)

- ☐ Cancer *type* _____
- ☐ Diabetes *type* _____
- ☐ High Blood Pressure
- ☐ Heart Disease
- ☐ Heart Attack
- ☐ Angina/Chest Pain
- ☐ Stroke/TIA
- ☐ Bleeding Disorder
- ☐ Osteoarthritis
- ☐ Osteoporosis
- ☐ Rheumatoid Arthritis
- ☐ Autoimmune Disease
- ☐ Hyper/Hypothyroidism
- ☐ HIV, HEP B, HEP C
- ☐ Tuberculosis
- ☐ Anemia
- ☐ Frequent/Severe Headaches
- ☐ Blood Clot
- ☐ Seizures/Epilepsy
- ☐ Kidney Disease
- ☐ GERD/Ulcers
- ☐ Emphysema/COPD
- ☐ Multiple Sclerosis/Parkinson's
- ☐ Other: _____

In the past year have you had:

- ☐ Falls *how many* _____
- ☐ Dizziness/Fainting
- ☐ Nausea/Vomiting
- ☐ Urinary/Fecal Leakage
- ☐ Urinary Fecal Urgency
- ☐ Other change to Bowel/Bladder function
- ☐ Unexplained Weight Change
- ☐ Difficulty sleeping
- ☐ Menstrual Irregularities
- ☐ Fever/Chills/Sweats
- ☐ Difficulty swallowing
- ☐ Double vision
- ☐ Pain with sexual activity
- ☐ Numbness/Tingling *where* _____
- ☐ A motor vehicle/workplace accident

Are you pregnant? Yes / No

Do you drink alcohol? Yes/No If yes, how many drinks per week: _____

Do you or have you ever smoked or used tobacco products? Yes/No

If yes do you smoke cigarettes, vape, chew or other? _____

How many _____ packs x _____ years. Date of last tobacco use. _____

Have you had any recent x-rays, MRI, CT, Nerve Conduction Studies? If so what did they show?

_____

_____

Please list any surgeries with dates of surgery if possible:

_____

_____

_____

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

As part of my health care, **Four Pines Physical Therapy** (The Company) creates and stores information about me. This includes records concerning my health history, symptoms, examinations, test results and plans for future care.

I understand that this information serves as a basis for my continuing care. I understand that this information is used as a means of communication among The Company's personnel, and with medical personnel outside of this practice. I understand that this information serves as a source of information for applying my diagnoses and surgical information to my bill.
I understand that this information is a way for third party insurance companies to assure that a service we billed for was actually performed.

I understand that this information can be used as a tool to assess the quality of care provided to patients. I have been provided an opportunity to review the Notice of Privacy Practices for The Company that provides a more complete review of information uses and disclosures. I understand that I have the right to review this Notice of Privacy Practices before signing this consent.

I understand that The Company may change its Notice of Privacy Practices at any time and that a current copy will be available for my inspection during regular business hours of each medical office and at the central billing office.

I understand that I have the right to request restrictions as to how my information may be disclosed to carry out treatment, payment or other healthcare operations and that The Company is not required to agree to the restrictions requested. The procedure to request restriction on information use and disclosure is contained in the Notice of Privacy Practices.

I acknowledge that I have received a copy of the Notice of Privacy Practices of Four Pines Physical Therapy and agree to the liability limitations explained therein.

Signature of patient or legal representative	Date	Relationship to Patient

Printed name of patient
Effective April 14, 2003
Revised September 12, 2013
Revised September 19, 2018

Witness Signature

Witness Printed Name

Attendance Policy Last Revised 1/24/23

At FOUR PINES PHYSICAL THERAPY, our goal is to help all patients meet their therapy goals. Your physical therapist will discuss your plan for care during the evaluation appointment and will inform you of the estimated number of visits necessary to help you achieve your goals. **Patients who attend all their physical therapy visits are 93% more likely to fully recover** from an injury, whereas, those that miss even one visit have a lower potential for recovery. We share this with you to show that it is extremely important that you attend all your appointments. This policy ensures that all patients have the opportunity to receive the care they need.

Please read our policy and sign at the bottom indicating you understand our expectations and our policy.

1. As rehab experts, we know that **you will reach full recovery quicker if you attend all your appointments**. To help ensure you have the best chance at recovery, we will work with you to schedule out all your appointments after your evaluation.
2. Our goal is to begin your treatment sessions on time. For all appointments we expect that you will arrive on time. This will allow our front office to handle their responsibilities and our specialists to provide the care you need and deserve.
3. If you are late for your appointment, you are missing the time that we have specifically scheduled for your care, and we cannot guarantee that we will be able to provide you with your full treatment as we have reserved the appointment time following yours for someone else.
4. If you are running late, we need you to call us immediately so we can prepare for your late arrival and consult with your clinician. If you are more than 10 minutes late, your session may need to be rescheduled. If that occurs, you may incur a missed visit charge.
5. Providing care to all patients is extremely important to us and late notice of changes or cancellations will keep someone else from getting the care they need and deserve.
    a. **To avoid our missed visit fee, we ask that if you need to cancel an appointment, you call our office during business hours the day before your appointment (by 12:00 p.m. the prior business day or Monday by 7:00 a.m.)** For reference, if you had an appointment at 11am today, we would need to have heard from you by 12:00 p.m. yesterday.
    b. **We reserve the right to charge a missed visit fee of $75 if you do not provide notice as outlined above. Any fee charged under this policy will be collected from you at your next appointment. The missed visit fee will still apply even if you reschedule your appointment.**
    c. When you call to cancel or change an appointment, have your schedule ready as we will reschedule you right away.
    d. While we understand that illness can strike at any time, we expect that, when possible, you will provide a day's notice, so we have time to offer the appointment to another patient who may be on the waitlist.
    e. Patients who have multiple same-day cancellations or no-shows, will be removed from the active schedule, and will be placed on the day-to-day list to avoid future missed visits.
    f. If you are worker's comp, we are required to notify your claims adjuster if you cancel or no-show for more than one appointment.

We look forward to working with you to meet your physical therapy goals. To remain in compliance with our policy, we only need the required notice, so we have enough time to help all patients to get in for the care they need and deserve.

This policy has been reviewed with me and by signing below I am indicating that I understand and agree to this policy.

Patient Signature	Printed Name	Date
Staff Signature	Date	